Placer County Systems of Care

ICD-10 Diagnosis Form

Diagnosis to be cross-walked to an ICD-10 diagnosis prior to being entered on this form.

Client Name: _____ **Case Number:** _____

Type of Diagnosis: ☐ **Admission** ☐ **Discharge** ☐ **Update**

Axis I: Clinical Disorders; Other Conditions That May Be a Focus of Clinical Attention

___ ___ ___ . ___ ___	**(Primary)**	a.
___ ___ ___ . ___ ___		b.
___ ___ ___ . ___ ___		c.
___ ___ ___ . ___ ___		d.

Substance Abuse/Dependency:

Does a substance abuse/dependency issue exist? ☐Yes ☐No ☐Unknown/Not Reported

If yes, which substance disorder is the primary substance abuse diagnosis? ☐a ☐b ☐c ☐d

Axis II: Personality Disorders; Mental Retardation

___ ___ ___ . ___ ___

___ ___ ___ . ___ ___

General Medical Condition (Axis III): Summary by Client Report or Medical Record Documentation

☐ Allergies	☐ Carpal Tunnel	☐ Epilepsy/Seizures	☐ Migraines	☐ Physical Disability
☐ Anemia	☐ Chronic Pain	☐ Heart Disease	☐ Multiple Sclerosis	☐ Psoriasis
☐ Arterial Sclerotic Disease	☐ Cirrhosis	☐ Hepatitis	☐ Muscular Dystrophy	☐ STDs
☐ Arthritis	☐ Cystic Fibrosis	☐ Hypercholestoralemia	☐ No General Medical Condition	☐ Stroke
☐ Asthma	☐ Deaf/Hearing Impaired	☐ Hyperlipidemia	☐ Obesity	☐ Tinnitus
☐ Birth Defects	☐ Diabetes	☐ Hypertension	☐ Osteoporosis	☐ Ulcers
☐ Blind/Visually Impaired	☐ Digestive Disorders	☐ Hyperthyroid	☐ Other	☐ Unknown/ Not Reported
☐ Cancer	☐ Ear Infections	☐ Infertility	☐ Parkinson's Disease	

Axis IV: Psychosocial and Environmental Problems (DSM-IV TR). *Check yes or no for each problem.*

Primary Support Group	☐ Yes ☐ No	Occupational	☐ Yes ☐ No	Access to Health Care	☐ Yes ☐ No
Social Environment	☐ Yes ☐ No	Housing	☐ Yes ☐ No	Legal System/Crime	☐ Yes ☐ No
Educational	☐ Yes ☐ No	Economic	☐ Yes ☐ No	Other Problems	☐ Yes ☐ No

Trauma:

Has the client witnessed violence, lived through a natural disaster, been a combatant or civilian in a war zone, witnessed or been a victim of a severe accident, or been the victim of physical, emotional, or sexual abuse? ☐ Yes ☐ No ☐ Unknown

Axis V: Global Assessment of Functioning Scale (GAF)

Current: Highest in last 12 months: Lowest in last 12 months:

Print Name of Diagnosing Practitioner: _____ **Date:** _____

(Must be Master's level or above)

Signature of Licensed/Registered Practitioner: _____ **Date:** _____

(Must include licensure after signature)